STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375286	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Purcell Care Center	801 North 6th Street Purcell, OK 73080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46387 Based on record review and interview, the facility failed to report an allegation of abuse within two hours for two (#1 and #2) of three sampled residents reviewed for abuse. The DON identified 54 residents resided in the facility. Findings: An abuse policy, dated 08/12/22, documented allegations of abuse must be reported within two hours. A progress note, dated 09/01/24 at 4:00 p.m., documented Res #1 had reported to staff Res #2 had been sexually inappropriate toward them. An initial incident report submitted to OSDH was dated as received 09/03/24 at 3:25 p.m. On 09/05/24 at 2:48 p.m., the administrator stated the incident report was submitted late.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE